The Pennsylvania Supreme Court published a landmark ruling on June 20, 2017 explaining a physician’s duty to provide information to a patient sufficient to obtain legally valid informed consent. In Shinal v. Toms, 162 A.3d 429 (Pa. 2017), the Supreme Court held that a physician’s duty to provide information to a patient sufficient to obtain her informed consent is non-delegable. A physician cannot rely upon a subordinate (including a physician assistant or anyone else) to disclose the information required to inform consent.

The Supreme Court’s decision did not contemplate how a physician’s non-delegable duty to obtain informed consent affects anesthesia practices and the practicality of how informed consents are obtained for scheduled surgeries. PSA has considered many questions and scenarios from its members. Below is a consolidated list of frequently asked questions regarding the informed consent process for anesthesia care related to the recent PA Supreme Court Decision:

1. Who is able to provide the informed consent discussion for anesthesia?
   - The Supreme Court decision holds that a physician may not delegate to others his or her obligation to provide sufficient information in order to obtain a patients’ informed consent. The Court also indicated that informed consent requires direct communication between physician and patient, and contemplates a back and forth, face to face exchange, which might include questions that the patient feels the physician must answer personally before the patient feels informed and becomes willing to consent. Physicians may no longer use the assistance of physician colleagues, residents, PAs, CRNPS, CRNAs or any other practitioners to perform the duty.

2. Often a patient has been seen preoperatively by one anesthesiologist but, due to the nature of anesthesia care, a second anesthesiologist is responsible for initiating anesthesia care. Is a second informed consent process necessary?
   - According to the decision, the physician performing the surgery or treatment “owes the patient” the discussion necessary to obtain informed consent. If the patient is mentally capable of the discussion, the second anesthesiologist should provide the information and allow the “face to face, back and forth exchange” and also sign, time and date the Consent form, indicating that they provided the discussion and when it occurred. There is a reasonable argument that a new Consent Form does not have to be completed or signed by the patient.
• If the change of personnel occurs after the patient has been sedated to the point of not being able to participate, hospital counsel have advised anesthesiologists to proceed with the anesthetic.

3. Many hospital departments and divisions obtain informed consents in clinics and they are not certain who the operating surgeon or attending anesthesiologist will be on the day of the actual surgery (e.g. anesthesia clinic, OB surgery, plastic surgery and pediatric surgery). Who should obtain the informed consent and sign the informed consent form in the clinic based on this practice?

• The Supreme Court decision does not contemplate this question specifically. It appears that one reasonable approach would be for the attending physician from the division or department, who is one of the physicians who could be operating or administering or overseeing the anesthesia, should obtain the consent and fill out the form at the clinic visit. If possible, any internal informed consent forms should continue to list all of the physicians who could be involved. If the attending surgeon or anesthesiologist was not the physician who obtained the original informed consent, PSA recommends the physician (a) acknowledge with the patient on the surgery/procedure date that his/her colleague, Dr. __________, previously obtained the consent; (b) ask the patient if they have additional questions for the anesthesiologist today; and (c) have a new form signed that day by the patient and the attending physician. This appears to best meet the spirit of the law while recognizing how this works in practice.

4. Can CRNAs obtain consent if they will be administering the anesthesia with attending physician oversight?

• No. The attending physician must obtain the informed consent.

5. Often transfer of care of a patient occurs from one anesthesiologist to another during the anesthesia. If that occurs, do we need to prospectively identify the second anesthesiologist to be involved with the consent process or contact a family member or power of attorney?

• No

6. Are the residents/fellows or CRNAs allowed to provide any information to the patient?

• The specific discussion regarding risk, benefits, and alternatives sufficient for the patient to provide consent must be done personally by the attending physician anesthesiologist who is credentialed and privileged by the facility to be ultimately responsible for the
anesthetic. The resident/fellow or CRNA can answer questions regarding specific technical and process elements of the anesthetic and can provide the patient with the Anesthesia Consent form for review. Any questions specific to risk, benefits, or alternatives are to be referred to the attending physician anesthesiologist. Only the attending physician anesthesiologist should sign the form as the person who provided the informed consent discussion.

7. In some facilities, nerve blocks are performed by one anesthesiologist and a second anesthesiologist is responsible for the intraoperative anesthetic. Often these patients receive sedatives during the block. Because of this, the consent for both the nerve block and the anesthesia is often obtained by the anesthesiologist performing the block. How do we handle this situation?

- Nerve blocks are performed as either blocks for postoperative pain (separate from the anesthetic) or for surgical anesthesia. If for surgical anesthesia, a single consent form and consent process for the anesthetic can be provided by the anesthesiologist performing the block without the anesthesiologist responsible for the intraoperative care having to do anything else (treated like a transfer of care, as the anesthetic has been initiated with placement of the nerve block). If the nerve block is for post-operative pain, two informed consent processes should occur: one for the block; and one for the anesthesia. The recommendation of some facilities, if the consents cannot be coordinated knowing the physicians to be involved in the anesthesia care, is to continue to have the physician performing the block provide the discussion and obtain the signed consent for both. When the anesthesiologist who is responsible for the anesthesia care is known, and if the patient is able participate, a second discussion takes place by that anesthesiologist, who provides his signature additionally in the physician line of the consent form. If the patient is unable to participate, the recommendation is to proceed with the anesthetic.

8. This decision poses particular problems with ICU patients for whom we have to obtain consent from family members or powers of attorney (“POA”). Currently, some facilities attempt to obtain these consents the night before, by the call or late anesthesiologists, to prevent delays the morning of surgery. Does the consent discussion still need to be by the anesthesiologist responsible for the anesthetic the day of surgery?

- Ideally, the consent discussion should be performed by the anesthesiologist responsible for the anesthetic the day of surgery. Specific work flow changes based on current practice at the sites are likely necessary. If the physician responsible for the anesthesia is unavailable or unknown, the discussion can take place
by any physician anesthesiologist, with the consent form completed as is currently done. During discussion with the family or POA, a phone number or other contact information should be obtained and documented prominently to allow the responsible physician to perform the required discussion the day of surgery.

9. Some facilities have the availability of a 30-day consent form. This ruling suggests that we will no longer be able to use this form.

- Correct. Because the informed consent discussion is owed by the physician anesthesiologist responsible for the anesthetic the day of surgery, a 30 day consent form is no longer legally viable, and the consent discussion must take place prior to each procedure unless the actual attending anesthesiologist is known, meets the patient, and discussed the anesthetic sometime before the day of surgery.